OUR ACTION PLAN for HEALTHY WEIGHT

Patient Name:_____ **Date:** _____

Provider: _____

WEIGHT CATEGORY (circle one)	**DEFINITION**
Unhealthy	***BMI >95%:*** The child's weight is not healthy.
May be Unhealthy	***BMI 85-95%:*** The child may be at an unhealthy weight.
Healthy	***BMI 5-84%:*** The child's weight is healthy.
Underweight	***BMI <5%:*** The child is at a weight that may not be high enough for best health.

GOALS:

How important do you feel it is to make healthy changes in eating or activity? (please circle a number)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Not important at all **Most important thing right now**

Choose 1-3 goals	
Fruits and Veggies (5) 	☐ Try to **eat 5** fruits and vegetables every day - keep track ☐ Fill **half of everyone's plate** with fruits and vegetables ☐ Include a fruit or vegetable in **every snack** ☐ **For preschoolers**, give a **sticker** for trying a vegetable ☐ **Doing Well**
Less Screen Time (2) 	☐ Limit TV and video games to **less than 2 hours** a day ☐ Move TV/computer/video games/other screens **out of bedrooms** ☐ **Unplug the family** for a week - no TV ☐ Have a child **choose 1-2 favorite shows:** _____ ☐ **Doing Well**
More Physical Activity (1) 	☐ **Play outside** 1 hour every day ☐ Go to a **park or playground**_____times/week ☐ Join a **sports team or rec center** ☐ Give kids **active chores** to help out at home ☐ **Doing Well**
No Sweet Beverages (0) 	☐ Together as a family, **stop drinking** drinks sweetened with **sugar** ☐ Drink **no more than ½ cup (4oz) juice** a day ☐ Drink **low-fat milk, or fat free after 2 years** ☐ Drink **more water:**_____glasses/bottles a day ☐ **Doing Well**
Other Goals	
Family Meals 	☐ Eat **dinner as a family** _____ times/week ☐ **Turn TV off** during meals and enjoy talking as a family ☐ Parents serve **smaller portions** of _____ ☐ Eat from **restaurants less:**_____times/week ☐ **Doing Well**
Breakfast 	☐ Eat **breakfast every day** ☐ **Pick cereals** with less than 8 grams sugar and at least 3 grams fiber ☐ **Doing Well**
Sleep 	☐ Go to **bed earlier** at_____o'clock ☐ **Move TV** out of the bedroom ☐ **Stop eating** after_____o'clock ☐ **Doing Well**

How confident are you that you can make the changes you picked? (please circle a number)

0-----1-----2-----3-----4-----5-----6-----7-----8-----9---------- 10

Not confident at all **Very confident**

Barriers Addressed: _____

Comments: _____

Patient Signature:_____ **Guardian Signature:** _____

Clinician Signature:_____ **Visit Date:** _____

Follow up:_____ **Stage: (circle) 1 2 3 4**

Referral:_____ **Phone #:** _____